Coordinating Center use only
Rec'd .....
Log'd .....
Chk'd .....
Entr'd .....

OHTS IOP Confirmation Visit: CF

Patient ID: SITE | IDNUM | NAMECODE 9

Date: EXAMDATE = FORMDATE 19
mm dd yy

Visit Type

1. ☑ Reason for visit: *RSNVISIT

*Recode prior versions: if rsnvisit = '3' then rsnvisit = '4'. Also changed version 8 program & $ vreason format.

☐1 To confirm IOP goal is reached (4 weeks following change in medication)
☐2 To confirm previously elevated IOP (following no change in medication)
☐3 OHTS II transition visit
➢ Complete a Transition Visit Status (TV) form and mail with this CF
☐4 Other, please explain: _____ 25

2. Which regularly scheduled visit does this IOP visit follow? VISIT
☐ 078 mo. ☐ 090 mo. ☐ 102 mo. ☐ 114 mo. ☐ 126 mo. ☐ 138 mo. ☐ 150 mo. ☐ 162 mo.
☐ 084 mo. ☐ 096 mo. ☐ 108 mo. ☐ 120 mo. ☐ 132 mo. ☐ 144 mo. ☐ 156 mo. ☐ 168 mo. 26

3. This is the: first CF ☐ 1 / second CF ☐ 2 / third CF ☐ 3 / fourth CF ☐ 4 / _____ ☐ 5 since the last regularly scheduled follow-up visit. 29
CFSEQ

4. If information on this form was obtained from a non-OHTS office, check here NONOHTS 30

➢ **If checking #4, also complete certification:** FORMBY 31

END 01

Checklist

☑ When completed.
☐ Before exam, patient completes Symptom Checklist
☐ Review Symptom Checklist with patient and complete AE, as needed
☐ Applanation tonometry
☐ Brief external and slit lamp exam
☐ Direct ophthalmoscopy
☐ Prescribe ocular medication
☐ Schedule return visit
☐ Send original forms to Coordinating Center (within 1 week)

Return Visit Schedule:

➢**If IOP goal is met, resume routine follow-up schedule.**
➢**If IOP goal is not met and treatment is altered, schedule IOP confirmation visit in 4 ± 2 weeks**

➢**Date of next appointment:** ☐☐ / ☐☐ / ☐☐
mm dd yy

OHTS IOP Confirmation Visit: CF

Patient ID: SITE IDNUM NAMECODE 9

Date: EXAMDAT2 19
mm dd yy

Snellen Visual Acuity Using Current Refraction

1. **Snellen visual acuity** **OD** VAOD1 / VAOD2 25

2. **Snellen visual acuity** **OS** VAOS1 / VAOS2 30

Snellen visual acuity taken by VABY 35

END02

OHTS IOP Confirmation Visit: CF

➢ **IOP is measured by two people**
- the OPERATOR aligns the mires
- the RECORDER reads the dial

Patient ID: SITE | IDNUM | NAMECODE 9

Date: EXAMDAT3 (mm dd yy) 19

IOP Determination

			OD	OS	
1.	**Time of measurement**	IOPTIME1 ☐ 1 am ☐ 2 pm			25
2.	**1st IOP**		IOP1_1OD	IOP1_1OS	30
3.	**2nd IOP**		IOP1_2OD	IOP1_2OS	34

Are the 1st and 2nd IOP determinations less than or equal to 2 mm Hg apart?
Yes: Enter their average on line **5**.
No: Take a 3rd reading and enter on line **4**.

4.	**3rd IOP**		IOP1_3OD	IOP1_3OS	38

➢If a 3rd IOP is taken, enter the median (middle value) of 1st, 2nd, and 3rd IOP on line **5.**

5.	**IOP Result**		IOP1OD	IOP1OS	42

➢Round to nearest whole number
➢Round up when decimal is .5 or greater

Operator Certification IOP1OPBY Recorder Certification IOP1RCBY 46

Removed Group distinction (and skipout)

6.	**Is IOP goal met?**	IOPMETS ☐1 Yes ☐2 No ☐3 Not applicable		IOPMETS ☐1 Yes ☐2 No ☐3 Not applicable	52
7.	**If IOP goal is met, you have three options:**				
a.	No change in treatment regimen		IOP1MNCD	IOP1MNCS	54
b.	Change treatment regimen due to symptoms		IOP1MSXD	IOP1MNCS	56
	➢**Complete Adverse Event Form**				
c.	Change treatment regimen for other reason(s) describe: _____		IOP1MOTD	IOP1MOTS	58
8.	**IF IOP goal is not met, you have six options:**				
a.	Instill drops and remeasure IOP		IOP1NRED	IOP1NRES	60
	➢**Complete IP Form**				
b.	Instruct patient to use eye drops on schedule		IOP1NSRD	IOP1NSRS	62
	➢Schedule return visit in 4 ± 2 weeks				
c.	Change medication this visit		IOP1NCMD	IOP1NCMS	64
	➢Schedule return visit in 4 ± 2 weeks				
d.	Change medication due to symptoms		IOP1NSXD	IOP1NSXS	66
	➢Schedule return visit in 4 ± 2 weeks				
	➢**Complete Adverse Event Form**				
e.	No change, already on maximum meds		IOP1NMMD	IOP1NMMS	68
f.	No change, patient declines medications		IOM1NMPD	IOP1NMPS	70
g.	Other action, describe: _____		IOP1NOTD	IOP1NOTS	72

_____

END03

OHTS IOP Confirmation Visit: CF

Patient ID: SITE IDNUM NAMECODE 9

Date: EXAMDAT5 19
mm dd yy

Summary of Ocular Examination

1. **External examination:**

OD	OS
EXTEXAMD 1 Normal 2 Abnormal	EXTEXAMS 1 Normal 2 Abnormal 25
If **abnormal**, describe:	If **abnormal**, describe:
_____	_____
_____	_____
_____	_____

2. **Slit lamp examination:**

OD	OS
SLEXAMD 1 Normal 2 Abnormal	SLEXAMS 1 Normal 2 Abnormal 27
If **abnormal**, describe:	If **abnormal**, describe:
_____	_____
_____	_____
_____	_____

3. **Direct ophthalmoscopic examination:**

OD	OS
OPHEXAMD 1 Normal 2 Abnormal (other than disc hemorrhage)	OPHEXAMS 1 Normal 2 Abnormal (other than disc hemorrhage) 29
If **abnormal**, describe:	If **abnormal**, describe:
_____	_____
_____	_____
_____	_____

4. **If disc hemorrhage:** (check here)

OD	OS
DISCHEMD 1 Yes	OPHEXAMS 1 Yes 31
and list clock hours:	and list clock hours:
CLCKHRD1 to CLCKHRD2	CLCKHRS1 to CLCKHRS2 33

Investigator Certification: EXAMBY 49

END04

OHTS IOP Confirmation Visit: CF

Patient ID: SITE | IDNUM | NAMECODE 9

➢**Dispense sufficient medication for 6 months.**
➢**"Qty" refers to number of bottles dispensed.**

Date: EXAMDAT6 (mm dd yy) 19

Ocular Medication Prescribed

	OD	OS	Dosage (# times daily)		Qty	Lot # *(Optional-- for clinic use)*	✓ if not from OHTS supply	✓ if none dispensed
1. Beta-Blockers								
Betoptic S 0.25%	BETOP25D	BETOP25S		25			☐	☐
Betagan 0.25%	BETAG25D	BETAG25S		27			☐	☐
Betagan 0.50%	BETAG50D	BETAG50S		29			☐	☐
Betimol 0.50%	BETIM50D	BETIM50S		31			☐	☐
Timoptic 0.25%	TIMOP25D	TIMOP25S		33			☐	☐
Timoptic XE 0.25%	TIMOX25D	TIMOX25S		35			☐	☐
Timoptic 0.50%	TIMOP50D	TIMOP50S		37			☐	☐
Timoptic XE 0.50%	TIMOX50D	TIMOX50S		39			☐	☐
OptiPranolol 0.30%	OPTIP30D	OPTIP30S		41			☐	☐
Ocupress 1.0%	OCUPR1D	OCUPR1S		43			☐	☐
2. Epinephrine/Dipivefrin								
Propine 0.1%	PROPI1D	PROPI1S		45			☐	☐
3. Alpha 2 Agonists	IOPID05D	IOPID05S						
Iopidine 0.5%	ALPHA02D	ALPHA02S		47			☐	☐
Alphagan-P 0.15%	ALPHP15D	ALPHP15S		49			☐	☐
4. Topical Carbonic Anhydrase Inhibitor								
Trusopt 2.0%	TRUSOPTD	TRUSOPTS		51			☐	☐
Azopt 1.0%	AZOPT1D	AZOPT1S		53			☐	☐
5. Prostaglandin Analogue								
Xalatan 0.005%	XALA005D	XALA005S		55			☐	☐
Rescula 0.15%	RESCU15D	RESCU15S		57			☐	☐
Lumigan 0.03%	LUMIGO3D	LUMIGO3S		59			☐	☐
Travatan 0.004%	TRAV004D	TRAV004S		61			☐	☐
6. Combination Therapy (Beta-Blocker/Topical Carbonic Anhydrase Inhibitor)								
Cosopt	COSOPTD	COSOPTS		63			☐	☐

END05

Complete Investigator Certification on page 6

OHTS IOP Confirmation Visit: CF

Patient ID: SITE | IDNUM | NAMECODE 9

➢**Dispense sufficient medication for 6 months.**
➢**"Qty" refers to number of bottles dispensed.**

Date: EXAMDAT6 19
mm dd yy

Ocular Medication Prescribed

1. Miotics	OD	OS	Dosage (# times daily)		Qty	Lot # *(Optional-- for clinic use)*	✓ if not from OHTS supply	✓ if none dispensed
Pilopine gel 4.0%	PILOG4D	PILOG4S	____	25	_____	_____	☐	☐
Pilocarpine 1.0%	PILOC1D	PILOC1S	____	27	_____	_____	☐	☐
Pilocarpine 2.0%	PILOC2D	PILOC2S	____	29	_____	_____	☐	☐
Pilocarpine 4.0%	PILOC4D	PILOC4S	____	31	_____	_____	☐	☐
Pilocarpine 6.0%	PILO6CD	PILOC6S	____	33	_____	_____	☐	☐
Carbachol 1.50%	CARB150D	CARB150S	____	35	_____	_____	☐	☐

2. Other Ocular Hypotensive Medication
Describe: _____
OTHMEDD | OTHMEDS ____ 37 _____ _____ ☐ ☐

3. Were any medications dispensed at this visit? ☐1 yes* ☐2 no 39
*If yes, complete question 3a.
MEDSDISP

3a. Have dispensed medications been logged on Monthly Drug Distribution Log? ☐1 yes ☐2 no 40
MEDSLOGD

4. If medication was not prescribed for one or both eyes check the following:

Eye(s)
NOMEDEYE
None – OD ☐1
None – OS ☐2
None – OU ☐3

Reason (Check all that apply) 41

- ☐1 **One-Eyed Trial** — NOMEDR1I
- ☐1 **Adverse Event (Complete AE Form)** — NOMEDRAE
- ☐1 **Treatment Change approved** — NOMEDRTC
- ☐1 **IOP goal met without medication** — NOMEDRIOPMET
- ☐1 **Patient declines medication (Check reasons):** — NOMEDRPD
  - ☐1 Side effects — NOMEDRPDSE
  - ☐1 Inconvenient — NOMEDRPDI
  - ☐1 Unable to self-dispense eye drops — NOMEDRPDU
  - ☐1 Patient thinks medications are not necessary — NOMEDRPDNN
  - ☐1 Patient feels he/she is already taking enough medications — NOMEDRPDENUF
  - ☐1 Personal philosophy — NOMEDRPDPP
  - ☐1 Other, describe: _____ — NOMEDRPDOT _____
- ☐1 **POAG Endpoint Reached** — NOMEDREN
- ☐1 **Other reason, describe:** _____ — NOMEDROT _____

Investigator Certification MEDSBY 56